



If the private sector adopts the concept of accountable care organizations (ACOs)—where health care providers have incentives to work together to treat an individual across care settings—patient care could improve and costs could go down.

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Accountable Care Organizations May Revolutionize Health Care

by | John C. Garner, CEBS

Some experts have speculated that the new accountable care organizations (ACOs) created under the health care reform legislation may be the most significant feature of that legislation, particularly if the private sector also adopts this model of care.

On March 31, 2011, the U.S. Department of Health and Human Services (HHS) released proposed rules to help doctors, hospitals and other health care providers better coordinate care for Medicare patients through ACOs. ACOs are intended to create incentives for health care providers to work together to treat an individual patient across care settings—including doctors' offices, hospitals and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower health care costs while meeting performance standards on quality of care and putting patients first. Provider participation in an ACO is purely voluntary.

The proposed rules are intended to help doctors, hospitals and other providers form ACOs and are now available for public comment. By focusing on the needs of patients and linking payment rewards to outcomes, this delivery system reform, as part of the Patient Protection and Affordable Care Act (PPACA), is intended to help improve the health of individuals and

communities while saving as much as \$960 million over three years for the Medicare program.

Under the proposal, ACOs—teams of doctors, hospitals, and other health care providers and suppliers working together—would coordinate and improve care for patients with original Medicare (that is, who are not in Medicare Advantage private health plans). To share in savings, ACOs would meet quality standards in five areas:

- Patient/caregiver care experiences
- Care coordination
- Patient safety
- Preventive health
- At-risk population/frail elderly health.

The proposed rules also include protections to ensure patients do not have their care choices limited by an ACO. Beneficiaries will be free to choose other providers, but if they use the same primary care providers they have in the past, they should receive better coordination of care in the future.

If ACOs save money by getting beneficiaries the right care at the right time—for example, by improving access to primary care so that patients can avoid a trip to the emergency room—the ACO can share in those savings with Medicare. ACOs that do not meet quality standards cannot share in program savings, and over time, those that do not generate savings can be held accountable. The new program will be established on January 1, 2012.

The Centers for Medicare and Medicaid Services (CMS) says that it has a three-part aim:

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Thomson Reuters. 2010.

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1. Better care for individuals
2. Better health for populations
3. Lower growth in expenditures.

CMS says that an ACO should embrace the following goals:

- Put the beneficiary and family at the center of all its activities
- Ensure coordination of care for beneficiaries regardless of its time or place
- Attend carefully to care transitions, especially as beneficiaries journey from one part of the care system to another
- Manage resources carefully and respectfully
- Be proactive by reaching out to patients with reminders and advice that can help them stay healthy and let them know when it is time for a checkup or a test
- Collect, evaluate and use data on health care processes and outcomes sufficiently to measure what it achieves for beneficiaries and communities over time and use such data to improve care delivery and patient outcomes
- Be innovative in the service of the three-part aim
- Continually invest in the devel-

opment and pride of its own workforce.

CMS is proposing creating both a shared savings model (one-sided) and a shared savings/losses model (two-sided).

The regulations propose:

- An operational definition of an ACO
- Eligibility requirements for an ACO
- Requirements for an ACO to commit to a three-year participation agreement
- Data sharing with ACOs
- A methodology for assigning beneficiaries to an ACO
- Quality measures
- A methodology for measuring ACO performance
- A shared savings payment methodology
- Introducing risk into the shared savings program
- Monitoring ACO performance
- Grounds and procedures for terminating agreements.

CMS proposes to define an ACO as a legal entity that is recognized and authorized under applicable state law, as identified by a taxpayer identification number. An ACO would be comprised of an eligi-

ble group of ACO participants that work together to manage and coordinate care for Medicare fee-for-service beneficiaries and have established a mechanism for shared governance that provides all ACO participants with an appropriate proportionate control over the ACO's decision-making process. By *ACO participant*, CMS means a Medicare-enrolled provider of services and/or a supplier.

The statute lists the following groups of providers of services and suppliers as eligible to participate as an ACO:

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals.

In addition, the regulations allow critical-access hospitals to establish an ACO with broader collaborations by including entities such as federally qualified health centers and rural health centers and other Medicare-enrolled providers and suppliers.

The ACO's legal entity may be structured in a variety of ways, including as a corporation, partnership, limited liability company, foundation or other entity permitted by state law. The ACO must demonstrate a mechanism of shared governance that provides all ACO participants with appropriate control over the ACO's decision-making process.

If an existing entity, such as a hospital employing ACO professionals, would like to include as ACO participants other providers of services and suppliers that are not already part of its existing legal structure, a separate entity would have to be established. That entity would provide

all ACO participants a mechanism for shared governance and decision making.

An ACO must establish and maintain a governing body with adequate authority to execute the statutory functions of an ACO. The governing body may be a board of directors, board of managers or any other governing body that provides a mechanism for shared governance and decision making for all ACO participants and that has the authority to execute the statutory functions of an ACO.

In those instances where the ACO is comprised of a self-contained financially and clinically integrated entity that has a preexisting board of directors or other governing body, such as a hospital that employs ACO professionals, CMS proposes that the ACO would not need to form a separate governing body, as long as that governing body is able to meet all other criteria required for ACO governing bodies.

To be eligible for participation in the shared savings program, the ACO participants must have at least 75% control of the ACO's governing body. In addition, each of the ACO participants must choose an appropriate representative from within its organization to represent it on the governing body.

CMS proposes that ACOs be required to describe how they will partner with community stakeholders as part of their application. ACOs that have a community stakeholder organization serving on their governing body would be deemed to have satisfied that application criterion.

CMS is proposing a requirement that ACOs provide for beneficiary involvement in their governing processes. Specifically, CMS is proposing that ACOs will be required to demonstrate a partnership with Medicare fee-for-service beneficiaries by having beneficiary representation in the ACO governing body.

These community and beneficiary representatives offer benefits professionals and trustees an opportunity to become involved in the operation of ACOs, which may become the dominant form of health care delivery.

CMS has worked with other federal agencies, including the HHS Office of Inspector General (OIG), the Department of Justice (DOJ), the Federal Trade Commission (FTC) and Internal Revenue Service (IRS) in an attempt to ensure that providers and suppliers have the guidance they need to form ACOs without running afoul of the fraud-and-abuse, anti-trust and tax laws. Concurrently with the publication of this proposed rule, the following documents have been issued:

- A joint CMS and OIG notice and solicitation of public comments on potential waivers of certain fraud-and-

takeaways >>

- ACOs are intended to help improve the health of individuals and communities while saving as much as \$960 million over three years for the Medicare program.
- Participation is voluntary, but providers in ACOs can share in Medicare savings if beneficiaries get the right care at the right time.
- CMS proposes that ACOs be required to include beneficiary involvement—providing a role for benefits professionals and trustees—in their governance.
- Health care reform includes other measures intended to hold down Medicare costs, including the controversial Independent Medicare Advisory Board, intended to reduce the per capita rate of growth in Medicare spending.

abuse laws in connection with the Medicare Shared Savings Program

- A joint FTC and DOJ proposed antitrust policy statement
- An IRS notice requesting comments regarding the need for additional tax guidance for tax-exempt organizations, including tax-exempt hospitals, participating in the Medicare Shared Savings Program.

In addition, PPACA established a new Center for Medicare and Medicaid Innovation that will test innovative care and service delivery models. CMS is currently exploring how the Innovation Center will test alternative payment models for ACOs.

Other components of PPACA that are intended to hold down Medicare costs include:

- The *Hospital Value-Based Purchasing Program*, which is intended to link payments to quality and transform Medicare from a passive payer of claims to an active purchaser of care
- The *physician fee schedule value-based payment modifier*, a budget-neutral payment system that will adjust payments based on quality and cost
- The *National Pilot Program on Payment Bundling*, a voluntary program to encourage providers to improve care and achieve savings through bundled payments
- The *Hospital Readmissions Reductions Program*, under which hospital payments will be adjusted based on the dollar value of each hospital's percentage of potentially preventable readmissions
- *Independence at home medical practices*, composed of

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bio



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physician- and nurse practitioner-directed home-based primary care teams

- State option to provide health homes, with *health homes* defined as a designated provider or a health team selected by an eligible individual with chronic conditions to provide home health services
- Adjustments to hospital payments for hospital-acquired conditions
- New authority for physician assistants
- Hospice care payment reforms
- Reductions in payments to disproportionate share hospitals¹
- Review of misvalued codes² under the physician fee schedule
- Eliminating lump-sum payments for motorized scooters
- Provider screening
- Enhanced measures to combat fraud and abuse
- Reduction of period for submission of claims
- Requirements for ordering durable medical equipment or home health services.

Perhaps the most controversial provision in PPACA to hold down Medicare costs is the Independent Medicare Advisory Board (IPAB), which is intended to reduce the per capita rate of growth in Medicare spending. If the rate of growth is not held down to a target growth level equal to the annual growth of the U.S. gross domestic product (GDP), plus 1%,

IPAB will make recommendations to Congress. However, it cannot recommend rationing or increased cost sharing, increased premiums or increased taxes. IPAB would be able to stop covering certain types of services or providers and it would be able to reduce amounts paid to providers.

If Congress does not vote on the recommendations, the recommendations still become law. If Congress votes the recommendations down, but the president vetoes and Congress does not override the veto, they also become law. Because this takes some power over Medicare away from Congress and gives it to a board of unelected individuals, some people have objected to this provision. Others claim it is exactly what is needed because Congress has been too afraid of special interest groups to take the actions needed to keep Medicare costs under control. President Obama has proposed having IPAB act if Medicare spending rises faster than GDP plus 0.5%.

Many people have complained that PPACA does not do enough to control health care costs. It is true that it does not do much in the short term; however, the longer term impact of the changes described above could be quite significant, particularly if the private sector follows Medicare's lead, as it often does.

As ACOs evolve, health care delivery will look a lot like the Wild West for a while. We can anticipate three-way power struggles among hospitals, specialists and primary care providers. ACOs will be creative, which may lead to some fraud and abuse, but should also lead to innovative thinking and just might cut costs while improving the quality of care. ●

Endnotes

1. Disproportionate share hospital (DSH) adjustment payments provide additional help to hospitals that serve a significantly disproportionate number of low-income patients. States receive an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients whose care is now covered by other payers, such as Medicare, Medicaid, the Children's Health Insurance Program or other health insurance. This annual allotment is calculated by law and includes requirements to ensure that DSH payments to individual DSH hospitals are not higher than these actual uncompensated costs. Because health care reform will lead to more people having insurance, reductions are being made to DSH hospitals since they should receive more money from insured patients who formerly were without insurance.

2. Section 3134 of PPACA directed the secretary of HHS to specifically examine potentially misvalued services in seven categories: (1) codes and families of codes for which there has been the fastest growth; (2) codes or families of codes that have experienced substantial changes in practice expenses; (3) codes that are recently established for new technologies or services; (4) multiple codes that are frequently billed in conjunction with furnishing a single service; (5) codes with low relative values, particularly those that are often billed multiple times for a single treatment; (6) codes that have not been subject to review since the implementation of the Resource-Based Relative Value Scale (the so-called Harvard-valued codes); and (7) other codes determined to be appropriate by the secretary. Because misvalued codes may lead to excessive reimbursements, making appropriate adjustments should save Medicare money.